

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 1 FilmG222 11-4-51 et

10440

## CERTIFICATE OF DEATH

10440 51  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Republic, Md.</i>		c. LENGTH OF STAY IN 1b <i>4 mos.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Private home</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore, Md.</i>			
3. NAME OF DECEASED (Type or print) <i>Elva</i>		d. STREET ADDRESS <i>3 Deepdene Road</i>			
4. DATE OF DEATH <i>Oct. 24</i>	Middle <i>Meredith</i>	Month <i>Oct.</i>	Day <i>24</i>		
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 28, 1868</i>		
9. AGE (In years last birthday) <i>88 yrs.</i>	10. IF UNDER 1 YEAR <i>9</i>	11. IF UNDER 24 HRS. <i>26</i>	12. IF UNDER 24 HRS. <i>Hours</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Whitehall, Md.</i>	12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		
13. FATHER'S NAME <i>Samuel H. Meredith</i>	14. MOTHER'S MAIDEN NAME <i>Clarissa Tredaway</i>	Address <i>Mrs. Mayfield Gray, Port Republic, Md.</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>?</i>	17. INFORMANT <i>Mrs. Mayfield Gray, Port Republic, Md.</i>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. INTERVAL BETWEEN ONSET AND DEATH WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>5th Avenue</i>	20f. (City or town) <i>Madonna, Md.</i>	(County) <i>Madonna</i>	(State) <i>Md.</i>
21. I certify that I attended the deceased from <i>Sept. 17</i> , 1957, to <i>Oct. 24</i> , 1957, that I last saw the deceased alive on <i>Oct. 24</i> , 1957, and that death occurred at <i>8a</i> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>5th Avenue, Madonna, Md.</i>					
ACTUAL SIGNATURE <i>Katherine R. De Villarreal</i>	DATE SIGNED <i>Oct. 24, 1957</i>				
PHYSICIAN'S NAME (Type) <i>Katherine R. De Villarreal</i>	DATE SIGNED <i>Oct. 24, 1957</i>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Oct. 26, 1957</i>	22b. DATE THEREOF <i>Oct. 26, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Bethel Cemetery</i>	22d. LOCATION (City, town, or county) <i>Madonna, Md.</i>	(State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. G. Harkness &amp; Son Mutual Md.</i>	ADDRESS <i>100 W. Ward</i>	24a. REC'D BY REGISTRAR <i>10-26-57</i>	24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		

CERTIFICATE OF DEATH

RECEIVED

BUREAU V. 4  
RECEIVED  
OCT 30 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10441

Items 11, 12 Film G222 11-5-57 et

## CERTIFICATE OF DEATH

10441

Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <b>Calvert</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>25 hrs.</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert Co., Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>XO Adelina</b>		
3. NAME OF DECEASED (Type or print) <b>Mary Brooks</b>		First	Middle	
4. DATE OF DEATH <b>10 28 1957</b>		Last	Month Day Year	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mra. 14 1895</b>	
9. AGE (In years last birthday) <b>62</b>		10. IF UNDER 1 YEAR Months <b>6</b>	11. IF UNDER 24 HRS. Days <b>2</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <b>U.S.A. Maryland</b>		
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>William Height</b>		
14. MOTHER'S MAIDEN NAME <b>Caroline Smith</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Lillian Brooks Parran 56 Seton Pl. N.W. Wash.D.C.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>260x Diabetes Acidosis</b>				
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) <b>Diabetes</b>				
DUE TO (c) <b>Upper Resp Infection</b>				
INTERVAL BETWEEN ONSET AND DEATH <b>10/26/57</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (d)				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec 27 1956</b> to <b>Oct 28 1957</b> that I last saw the deceased alive on <b>Dec 27 1956</b> , and that death occurred at <b>10 A.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Page Jett</b> ADDRESS (Street, city or town, state) <b>Baltimore, Md.</b> DATE SIGNED <b>10/28/57</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-30-57</b>		22b. DATE THEREOF <b>10-30-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Carrolls</b>	22d. LOCATION (City, town, or county) <b>Baltimore, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. E. Sewell, Prince Fred, Md</b>		ADDRESS	24a. REC'D BY REGISTRAR DATE <b>10-31-57</b>	24b. REGISTRAR'S SIGNATURE <b>H. W. Ward</b>

## CERTIFICATE OF DEATH

BUREAU V. 41

NOV. 1 1967

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

vs AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10442

## CERTIFICATE OF DEATH

10442

Reg. Dist. No. 51

## 1. PLACE OF DEATH

COUNTY Calvert

CITY (If outside corporate limits, write RURAL  
OR  
end give nearest town)

TOWN Prince Frederick

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

Calvert Co. Hospital

MARYLAND

LENGTH OF STAY  
(in this place)

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland

COUNTY Calvert

CITY (If outside corporate limits, write RURAL and give nearest town)

TOWN Owings

STREET  
ADDRESS

(If rural give location)

Prince Frederick md

3. NAME OF  
DECEASED  
(Type or Print)

(First) John (Middle) W. (Last) Brown

5. SEX

m

6. COLOR OR  
RACE

C

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)

8. DATE OF BIRTH

Unknown

9. AGE last birthday

73 yrs.

10. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired)

Farmer.

10b. KIND OF BUSINESS  
OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT  
COUNTRY?

U.S.A.

13. FATHER'S NAME

Joseph Brown.

14. MOTHER'S MAIDEN NAME

Sophia Gill

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.)

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT &amp; ADDRESS

Mr. Edith Thompson 1102 Vermont ave

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

442X IMMEDIATE CAUSE (A) Hypertension C.V.R disease

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE

STATING UNDERLYING CAUSE LAST. DUE TO

(C)

19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING

TO THE DEATH BUT NOT RELATED TO THE

DISEASE OR CONDITION CAUSING DEATH.

20. AUTOPSY?

YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  (If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
M. While at work  Not while at work 

21f. HOW DID INJURY OCCUR?

M. at work 

22. I hereby certify that I attended the deceased from 10/2 1951 to 10/4 1952, that I last saw the deceased

alive on 10/10 1952, and that death occurred at 1 A.M. from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

10/12/57

23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

10/13/57

Plain Point

Calvert Co. md

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

H. W. Ward

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

P. E. Seewell Prince Frederick md

# BUREAU V. 2

OCT 16 1957

# REFEVIEW

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10443

10443

## CERTIFICATE OF DEATH

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>maryland</i>		b. COUNTY <i>Calvert</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Busby</i>		c. LENGTH OF STAY IN 1b <i>1</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO Busby</i>		d. STREET ADDRESS <i>1</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i></i>				d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <i>Thomas</i>	Middle <i>m.</i>	Last <i>Cleaggett</i>	4. DATE OF DEATH <i>10-30 1957</i>	Month <i>10</i>	Day <i>30</i>	Year <i>1957</i>	
5. SEX <i>m</i>	6. COLOR OR RACE <i>c</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 6, 57</i>	9. AGE (In years lost birthday) yrs. <i>3</i>	IF UNDER 1 YEAR Months <i>3</i>	IF UNDER 24 HRS. Days <i>0</i>	Hours <i>0</i>	Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>maryland</i>		12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <i>Warren Cleaggett</i>		14. MOTHER'S MAIDEN NAME <i>Catherine Janeey</i>							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>catherine Janeey Busby, md.</i>		Address			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>490X</i>		DUE TO <i>Pneumonia (lobar)</i>				INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause lost.</u> (b)		DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) <i></i>		(County) <i></i>	(State) <i></i>
21. I certify that I attended the deceased from <i>10-22</i> , 19 <i>57</i> , to <i>10-30</i> , 19 <i>57</i> , that I last saw the deceased alive on <i>10-22</i> , 19 <i>57</i> , and that death occurred at <i>3:30</i> A.M., from the causes and on the date stated above.						ADDRESS (Street, city or town, state) <i>5th Avenue</i>		DATE SIGNED <i>10/30</i>	
ACTUAL SIGNATURE <i>R. W. Williams M.D.</i>									
PHYSICIAN'S NAME (Type) <i>R. W. Williams - 5th Avenue</i>									
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>11-1, 57</i>		22b. DATE THEREOF <i>11-1, 57</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Brooks</i>		22d. LOCATION (City, town, or county) <i>Island Creek, md</i>		(State) <i></i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. J. Seaville, Prince Fred, md</i>		ADDRESS <i></i>		24a. REC'D BY REGISTRAR DATE <i>11/5/57</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Hardy</i>			

THE COMMONWEALTH OF MASSACHUSETTS—BOSTON

DEPARTMENT OF PUBLIC HEALTH  
CERTIFICATE OF DEATH

MASSACHUSETTS

BUREAU V. S

NOV 5 1957

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10444

## 10444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 51

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute it on a certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings</i>	c. LENGTH OF STAY IN 1b <i>1b</i>	b. COUNTY <i>Calvert</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Owings</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>100</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>William</i>	First <i>Clagett</i>	Middle <i>Clagett</i>	Last <i>10</i>
4. DATE OF DEATH Month <i>7</i>	Month <i>1957</i>	Day <i>7</i>	Year <i>1957</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <i>Mar 22/1910</i>	9. AGE (In years last birthday) yrs. <i>57</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Food Army Handspand</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Food Army Handspand</i>	10c. BIRTHPLACE (State or foreign country) <i>Md</i>
11. FATHER'S NAME <i>John Clagett</i>		12. CITIZEN OF WHAT COUNTRY? <i>James Clagett Owings Md</i>	
13. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		14. MOTHER'S MAIDEN NAME <i>Madora Jefferson</i>	15. INFORMANT <i>James Clagett Owings Md</i>
16. SOCIAL SECURITY NO. <i>420.1</i>			
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Went to work felt badly and died at home</i>			
18. MEDICAL CERTIFICATION 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>10/7/57</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>fall</i>			
20c. TIME OF INJURY Month, Day, Year Hour <i>10/7 1957</i>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Owings Calvert Md</i>	20f. CITY OR TOWN (County) (State) <i>Owings Calvert Md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> <i>H. W. Ward</i>			
ACTUAL SIGNATURE <i>H. W. Ward</i>	DATE SIGNED <i>10/7/57</i>		
EXAMINER'S NAME (Type) <i>H. W. Ward</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL) CREMATION, REMOVAL (Specify) <i>Oct 10-57</i>	22b. DATE THEREOF <i>Oct 10-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St Edmonds</i>	22d. LOCATION (City, town, or county) (State) <i>Calvert, Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell, Jr. Fred. Md</i>		24a. REC'D BY REGISTRAR <i>10/10/57</i>	24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>

U. S. GOVERNMENT PRINTING OFFICE: 1957  
WIRELESS TELEGRAMS CERTIFICATE OF ORIGIN

BUREAU V. A.

OCT 15 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10445

Reg. Dist. No. 51

10445

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Washington D.C.</i>		b. COUNTY <i>Rural</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>1 yr</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington D.C. 47x-3</i>		d. STREET ADDRESS <i>1364 Quincy St., N.W.</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hosp. Annex</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <i>Cora M. Cole</i>		First	Middle	Last	4. DATE OF DEATH <i>Oct. 25, 1957</i>	Month	Day	Year
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <i>Apr. 11, 1864</i>	9. AGE (In years last birthday) <i>93</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>	13. MIN. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>		11. BIRTHPLACE (State or foreign country) <i>Leonardtown, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>George F. Maddox</i>		14. MOTHER'S MAIDEN NAME <i>Susan Ruth Harris</i>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>200-20-2000</i>		17. INFORMANT <i>Hospital Records - Prince Frederick, Md</i>		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>903.7</i>		DUE TO <i>Hyper Reeps</i>		INTERVAL BETWEEN ONSET AND DEATH <i>Not</i>				
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <i>(b)</i>		DUE TO <i>Pharyngitis</i>						
(c)		Fractured Hip						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Fell in Dove Room in Hospital</i>						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Calvert County Prince Frederick Calvert</i>		(County)		(State)
21. I certify that I attended the deceased from <i>Dec.</i> , 19 <i>56</i> , to <i>Oct. 25, 1957</i> , that I last saw the deceased alive on <i>Oct. 24, 1957</i> , and that death occurred at <i>11a</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Jaget Jett</i>						ADDRESS (Street, city or town, state) <i>Prince Frederick</i>		DATE SIGNED <i>10/25/57</i>
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Oct. 28, 1957</i>		22b. DATE THEREOF <i>Oct. 28, 1957</i>		22c. NAME OF CEMETERY OR CREMATORIAL <i>Fort Lincoln Cem.</i>		22d. LOCATION (City, town, or county) <i>Washington, D.C.</i>		(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Harkness &amp; Son - Mutual, Md.</i>		ADDRESS		24a. REC'D BY, REGISTRAR DATE <i>10/28/57</i>		24b. REGISTRAR'S SIGNATURE <i>N.W. Ward</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

BUREAU V. R

OCT 30 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

10446  
Reg. Dist. No. 51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>4 mos</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>BESSIE</i>	Middle <i>Cox</i>	4. DATE OF DEATH <i>Oct. 16, 1957</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 1, 1878</i>
9. AGE (In years last birthday) <i>79 yrs.</i>	10. IF UNDER 1 YEAR Months <i>5</i> Days <i>15</i>	11. IF UNDER 24 HRS. Hours <i>15</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Calvert Co., Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Alfred Crawford</i>		14. MOTHER'S MAIDEN NAME <i>Cassandra. Olessey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>000-00-0000</i>	
17. INFORMANT <i>Mr. Vesta Turner - Sunderland, Md.</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>170X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i>(b)</i> DUE TO <i>(c)</i> Secondary Melanoma to liver	
		INTERVAL BETWEEN ONSET AND DEATH <i>10 years</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>March 1956</i> to <i>Oct. 16, 1957</i> , that I last saw the deceased alive on <i>Oct. 16, 1957</i> , and that death occurred at <i>11:30 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>Page Jett</i>		ADDRESS (Street, city or town, state) <i>PRINCE FREDERICK</i> DATE SIGNED <i>10/18/57</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct. 18, 1957</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Emmanuel Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Plum Point - Calvert Co., Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. Q. Harkness &amp; Son - Mutual, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>10-18-57</i>	
		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Page 3 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

WISCONSIN STATE DEPARTMENT OF HEALTH - SANITATION  
CERTIFICATE OF DEATH

BUREAU V. S.

OCT 21 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10447

## CERTIFICATE OF DEATH

Reg. D1. No. 10447

## 1. PLACE OF DEATH

a. COUNTY

Calvert

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Prince Frederick

c. LENGTH OF STAY IN lb

4

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Calvert County Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)

a. STATE

Maryland

b. COUNTY

Calvert

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Prince Frederick

d. STREET ADDRESS

1

e. IS RESIDENCE  
ON A FARM?  
YES  NO 3. NAME OF  
DECEASED  
(Type or print)

First

Middle

Last

4. DATE  
OF  
DEATHMonth  
10  
Year  
1957Day  
20

Charles

Richard

Cox S.r.

5. SEX

Male

6. COLOR OR RACE

White

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

6-8-70

9. AGE (In years  
last birthday)  
77 yrs.10. IF UNDER 1 YEAR  
Months  
Days11. IF UNDER 24 HRS.  
Hours  
Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Farm owner

10b. KIND OF BUSINESS OR INDUSTRY

Farmer

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

James N. Cox

14. MOTHER'S MAIDEN NAME

Mary Ellen Gibson

15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unknown) (If yes, give war or dates of service)

No

214-36-399 Mrs. Daisy Cox, Prince Frederick, Md.

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

181X

— Dennis

INTERVAL BETWEEN  
ONSET AND DEATH

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last.

(b)

DUE TO

(c)

ca of Bladder

MEDICAL CERTIFICATION

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY  
Month, Day, Year  
Hour a. m. 19  
p. m.20d. INJURY OCCURRED  
White Not white  
at work  at work 20e. PLACE OF INJURY (Home, farm,  
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from Oct 20, 1957, to Oct 20, 1957, that I last saw the deceased  
alive on Oct 20, 1957, and that death occurred at 9:30 A.M. from the causes and on the date stated above.

ADDRESS (Street, city or town, state)

DATE SIGNED

ACTUAL  
SIGNATURE

M.D.

54 Leonard 10/20

PHYSICIAN'S  
NAME (Type)

R. DeVille, R.R. #1, S. Leonard, Md.

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

22b. DATE THEREOF

Burial Oct 22, 1957 Central Methodist Cemetery, Barstow - Calvert Co - Md

23. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

A. A. Harkness &amp; Son - Mutual, Md

24a. REC'D BY REGISTRAR

DATE 10-23-57

24b. REGISTRAR'S SIGNATURE

H. W. Ward

CERTIFICATE OF DEATH

BUREAU V. S.

OCT 24 1957

REGISTRY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10448

## CERTIFICATE OF DEATH

10448

Reg. Dist. No. 51

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE	
Cabret		Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Princes Frederick	3 days	x1 Dunkirk	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	d. STREET ADDRESS		
Cabret County Hospital	/		
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First	Middle	Last
J. C. ORVILLE		DRURY	
4. DATE OF DEATH	Month	Day	Year
Oct. 5	1957		
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May. 26, 1883
9. AGE (In years lost, birthday)	10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.	
74 yrs.	Months	Days	
	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farm Owner	Farming	Cabret Co., Md	
13. FATHER'S NAME	14. MOTHER'S M AIDEN NAME		
John H. Drury	Elizabeth Carcaud		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	?	John H. Roland Drury	Dunkirk, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]	INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia			
493X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 20 Sept., 1957, to 5 Oct., 1957, that I last saw the deceased alive on 5 Oct., 1957, and that death occurred at 10 45 M, from the causes and on the date stated above.	ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE D. J. Weems	DATE SIGNED 6 Oct 57		
PHYSICIAN'S NAME (Type) G. J. Weems	Huntingtown, Md		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 8, 1957	22c. NAME OF CEMETERY OR CREMATORI Shiloh Cemetery	22d. LOCATION (City, town, or county) Dunkirk, Cabret Co., Md
23. FUNERAL DIRECTOR'S SIGNATURE A. O. Mackness & Son - Mutual, Md	ADDRESS	24a. REC'D BY REGISTRAR DATE 10/17/57	24b. REGISTRAR'S SIGNATURE H. W. Ward

WISCONSIN STATE GOVERNMENT OF HEALTH—GULWIGE 15  
CERTIFICATE OF DEATH

BUREAU N.Y.  
OCT 9 1957  
RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10449

## CERTIFICATE OF DEATH

10449

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		b. COUNTY <i>Calvert</i>	
c. LENGTH OF STAY IN 1b <i>6 days</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown md</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		d. STREET ADDRESS <i>1</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>WILLIAM</i>	Middle <i>Pyles</i>	Last <i>FINK</i>
4. DATE OF DEATH	Month <i>Oct</i>	Day <i>19</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>April 26 1880</i>
9. AGE (In years last birthday) <i>77 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>	10b. KIND OF BUSINESS OR INDUSTRY <i>self employed</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Jacob Fink</i>	14. MOTHER'S MAIDEN NAME <i>unknown</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No.</i>	16. SOCIAL SECURITY NO. <i>706</i>	17. INFORMANT <i>Lena Fink - Huntingtown md</i>	Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i>		INTERVAL BETWEEN ONSET AND DEATH <i>15 hrs</i>	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.			
(b) <i>ART Scl C.V. DISEASE</i>			
(c) <i>PROSTATISM</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at _____, M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Page Jett</i>			
ADDRESS (Street, city or town, state) <i>PRINCE FREDERICK 10/1957</i>			
PHYSICIAN'S NAME (Type) <i>Page C Jett</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>10/22/57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St John's Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Beltsville, Maryland</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>F. Gasch's Sons</i>	ADDRESS <i>Hyattsville, Maryland.</i>	24a. REC'D BY REGISTRAR <i>OCT 23 1957</i>	24b. REGISTRAR'S SIGNATURE <i>Augh Hardy</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## CERTIFICATE OF DEATH

BUREAU V. L.

OCT 23 1957

RECEIVED BY

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10450

## CERTIFICATE OF DEATH

10450

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH o. COUNTY Cabell		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Breezy Point		c. LENGTH OF STAY IN 1b 10 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda	
d. STREET ADDRESS 04x21		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) AUGUSTINE		First H.	Middle GERARD
4. DATE OF DEATH	Month Oct.	Day 4	Year 1957
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 18, 1885
9. AGE (In years lost birthday) 72 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
10c. BIRTHPLACE (State or foreign country) France		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
12. FATHER'S NAME, Louis Humbert		13. MOTHER'S MAIDEN NAME ?	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		15. SOCIAL SECURITY NO. No	
16. INFORMANT Andre E. Gerard Sr.		17. INFORMANT Clinton, Md Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arterio occlusive C.V. disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct. 2, 1957, to Oct. 4, 1957, that I last saw the deceased alive on Oct. 2, 1957, and that death occurred at 3 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Prince Frederick, Md DATE SIGNED 10/4/57			
ACTUAL SIGNATURE Page S. J. St. M.D.		PHYSICIAN'S NAME (Type) Page E. VETI, M.D. Prince Frederick, Md	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation Oct. 6, 1957		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORIAL Lee's		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Lee Funeral Home Washington, D.C.		24a. REC'D BY REGISTRAR ADDRESS	
24b. REGISTRAR'S SIGNATURE R. W. Ward		DATE 10/8/57	

WELFARE STATE DEPARTMENT OF HAWAII—FALUN DAF

BUREAU V. S.

OCT 9 1957

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be examined by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10451

## CERTIFICATE OF DEATH

10451

Reg. Dist. No.

51

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Chesapeake</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Chesapeake</i>		d. STREET ADDRESS <i>1 Chesapeake</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Edward</i>	Middle <i>Gross</i>	4. DATE OF DEATH Last 10 26, 1957
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May, 19</i>
9. AGE (In years last birthday) 71 yrs.	10. IP UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			
13. FATHER'S NAME <i>Samuel Gross</i>		14. MOTHER'S MAIDEN NAME <i>Mariah Lake</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Edward Gross, Chesapeake, Md</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>480X</i>		Address <i>Edward Gross, Chesapeake, Md</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <i>Ill</i>		INTERVAL BETWEEN ONSET AND DEATH <i>16 h</i>	
DUE TO <i>Ill</i>			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Had been sick for a week</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Had been sick for a week</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19_____, to _____, 19_____, that I last saw the deceased alive on _____, 19_____, and that death occurred at 4:30 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>H. Ward, M.D.</i>		ADDRESS (Street, city or town, state) <i>Chesapeake, Md.</i>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL/CREMATION, REMOVAL (Specify) <i>10-29-57</i>		22b. DATE THEREOF <i>10-29-57</i>	
22c. NAME OF CEMETERY OR CEMATORIAL <i>St. Edmunds</i>		22d. LOCATION (City, town, or county) (State) <i>Calvert, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell Prince, Fred, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <i>10-31-57</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

DEPARTMENT OF PUBLIC SAFETY  
CERIFICATE OF DEATH

FEDERAL BUREAU OF INVESTIGATION  
U. S. DEPARTMENT OF JUSTICE

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 Film 6221 10-11-57 et  
10452 CERTIFICATE OF DEATH

10452  
51

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>5 days</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Calvert County Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>William</i>	Middle <i>J.</i>	Last <i>Higgs</i>
4. DATE OF DEATH	Month <i>10</i>	Day <i>7</i>	Year <i>1957</i>
5. SEX <i>Male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1/16/1884</i>
9. AGE (In years last birthday) <i>73 yrs.</i>	10. IF UNDER 1 YEAR Months <i>0</i>	11. IF UNDER 24 HRS. Days <i>0</i>	12. IF UNDER 24 HRS. Hours <i>0</i>
13. FATHER'S NAME <i>Alfred Higgs</i>	14. MOTHER'S MOTHER'S NAME <i>Mary Farrell</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES (Yes, no, or unknown) <i>No</i>	16. SOCIAL SECURITY NO. <i>191-03-6424</i>	17. INFORMANT <i>Mary Higgs</i>	Address <i>Benedict, Md.</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>540.1</i>			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Ruptured gastric ulcer</i> (c) <i>Coronary thrombosis</i>			
INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	20d. INJURY OCCURRED White at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Oct 3, 1957</i> to <i>Oct 7, 1957</i> , that I last saw the deceased alive on <i>Oct 3, 1957</i> , and that death occurred at <i>10 M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>R. D. Clement</i>	ADDRESS (Street, city or town, state) <i>57 Leonard St. -</i>		
PHYSICIAN'S NAME (Type) <i>R. D. VILLA REGAL</i>	DATE SIGNED <i>Oct 7, 1957</i>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Oct. 7, 1957</i>	22b. DATE THEREOF <i>Oct. 7, 1957</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>St. Leonard</i>	22d. LOCATION (City, town, or county) <i>Sugarcane - Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>G. A. Tasker &amp; Son</i>	ADDRESS <i>Mount, Md.</i>	24a. REC'D BY REGISTRAR DATE <i>10/8/57</i>	24b. REGISTRAR'S SIGNATURE <i>N. W. Ward</i>

## CERTIFICATE OF DEATH

MAILED

DEATH CERTIFICATE

REGISTRATION

NUMBER

ISSUED

TO

NAME

ADDRESS

CITY

STATE

ZIP

PHONE

NUMBER

EXPIRATION

DATE

YEAR

BUREAU V. S.

OCT 9 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10453 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10453

Reg. Dist. No. 51

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar, prior to burial, cremation, or removal.

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1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Sunderland</i>		c. LENGTH OF STAY IN 1b <i>1b</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>Sunderland</i>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First <i>Wilmer</i>	Middle <i></i>	Last <i>Holland</i>
4. DATE OF DEATH	10/3	Month	Day
5. SEX <i>M</i>	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 17</i>
9. AGE (In years last birthday) <i>40 yrs.</i>	10. IF UNDER 1 YEAR Months <i></i> Days <i></i>	11. IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>	
11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i></i>	
13. FATHER'S NAME <i>Henry Holland</i>		14. MOTHER'S MAIDEN NAME <i>Rutha Thomas</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i></i>	
17. INFORMANT <i>Henry Holland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>974X</i> DUE TO <i>Strangulation due to</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>self inflicted hangnij</i> DUE TO <i>Suicide</i> (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <i>found hangnij in Barn</i>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i></i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Strangulation</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>6:00</i> p. m. <i>10/3</i> <i>1957</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Sunderland</i> (County) <i>Calvert</i> (State) <i>Md</i>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i></i>		22b. DATE THEREOF <i>10-7-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>St Edmonds</i>		22d. LOCATION (City, town, or county) <i>Sunderland</i> (State) <i>Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P.E. Sewell Jr. Frederick, Md</i>		24a. REC'D BY REGISTRAR DATE <i>10/8/57</i>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <i>H.W. Ward</i>	

THE KICKER EX-WINNER'S CHATLINE IS ONE OF THE HOTTEST IN THE BUSINESS.

RECEIVED  
BUREAU Y. S.  
OCT 9 1957

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C-155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10454

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

## 1. PLACE OF DEATH

COUNTY *Calvert*  
 CITY (If outside corporate limits, write RURAL  
OR  
TOWN *Sunderland*)

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS  
00

## MARYLAND

LENGTH OF STAY  
(in this place)  
50 yrs

## 2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Calvert  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN *Sunderland*  
 STREET  
ADDRESS  
1

(If rural give location)

3. NAME OF  
DECEASED  
(Type or Print)(First)  
*WILLIAM*(Middle)  
*HENRY*(Last)  
*Ireland*4. DATE (Month)  
OF  
DEATH *Oct 23* (Day)  
(Year)  
19 57

5. SEX

6. COLOR OR  
RACE  
*white*7. SINGLE, MARRIED,  
WIDOWED, DIVORCED,  
(Specify)  
*widowed*

## 8. DATE OF BIRTH

*Aug. 18, 1869*9. AGE last birthday  
88 yrs.

IF UNDER 1 YEAR

Months

Days

Hours

Min.

10e. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if  
retired) *Farmer*10b. KIND OF BUSINESS  
OR INDUSTRY  
*Farm - owner*

11. BIRTHPLACE (State or foreign country)

*Maryland*12. CITIZEN OF WHAT  
COUNTRY?

## 13. FATHER'S NAME

*Henry Clay Ireland*

## 14. MOTHER'S MAIDEN NAME

*Louise Birchhead*15. WAS DECEASED EVER IN U. S. ARMED FORCES?  
(Yes, no, or unk.) *—* (If Yes, give war or dates of service) *—*

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS

*John B. Ireland, Sunderland, Md.*

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## 18. MEDICAL CERTIFICATION

INTERVAL BETWEEN  
ONSET AND DEATH420.1 IMMEDIATE CAUSE (A) *Coronary occlusion*

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, (B)

GIVING RISE TO THE ABOVE CAUSE DUE TO

STATING UNDERLYING CAUSE LAST. (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?  
YES  NO 21a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, NOTIFY MEDICAL EXAMINER)21b. PLACE (Home, farm, factory,  
OF INJURY street, office bldg., etc.)

21c. WHERE DID INJURY OCCUR? (City or town)

(County)

(State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour)

21e. INJURY OCCURRED  
While  at work   
Not while  at work 

21f. HOW DID INJURY OCCUR?

M.

22. I hereby certify that I attended the deceased from *2/10* 1949, to *10/23* 1957, that I last saw the deceased  
alive on *10/23* 1957, and that death occurred at *5 A.M.* from the causes and on the date stated above.

SIGNATURE

ADDRESS (Street, city, town, state)

DATE SIGNED

*10/24/57*23. BURIAL, CREMATION,  
REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORIAL

LOCATION (City, town, or county)

(State)

*Burial**Oct 25, 1957**Smithville Cemetery**Dunkirk, Maryland*

24. REC'D BY REGISTRAR

REGISTRAR'S SIGNATURE

25. FUNERAL DIRECTOR'S SIGNATURE

ADDRESS

*10/24/57**Grace L. Hutchins**7294 Hutchins**Owings, Md.*

RECEIVED BY THE NATIONAL SECURITY COUNCIL

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DEPARTMENT

STATE  
DEPARTMENT

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RECEIVED  
OCT 30 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10455

## CERTIFICATE OF DEATH

10455  
5/

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b <b>14 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Island Creek</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert Co., Hospital</b>		d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>John</b>	Middle <b>Jackson</b>	Last	4. DATE OF DEATH	Month <b>10</b>	Day <b>12</b>	Year <b>57</b>
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 14 1878</b>	9. AGE (In years (birthday) yrs.) <b>79</b>	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Jackson</b>		14. MOTHER'S MAIDEN NAME <b>Chaney Gantt</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>Wife Mamie Jackson</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>592x</b>		DUE TO <b>Chronic -</b>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		(b) <b>Chronic nephritis</b>					
(c) <b>Prostate</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month, Doy, Year 19	20d. INJURY OCCURRED White of work <input type="checkbox"/> Not white of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Island Creek</b>	(County)	(State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____, 19____, P. M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>58 Phenard, 1974</b>		DATE SIGNED	
ACTUAL SIGNATURE <i>R. De Villarreal</i>	M.D.						
PHYSICIAN'S NAME (Type) <b>Dr. Roberto De Villarreal</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-17-57</b>	22b. DATE THEREOF <b>10-17-57</b>	22c. NAME OF CEMETERY OR CREMATORIAL <b>Brook</b>	22d. LOCATION (City, town, or county) <b>Island Creek, Md</b>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <b>P. E. Sowell</b>		ADDRESS <b>Prince Frederick, Md.</b>	24a. REC'D BY REGISTRAR DATE <b>10-12-57</b>	24b. REGISTRAR'S SIGNATURE <b>H. W. Ward</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13

### Conclusion

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BUREAU V. S.

OCT 21 1957

REGELY ED



THE STATE OF KANSAS - BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

NO. 12345678

REGISTRATION NUMBER: 12345678

DECEASED PERSON'S NAME: JOHN D. DOWD

DEATH DATE:  
10/10/1957

PLACE OF DEATH:  
HOME

CAUSE OF DEATH:  
HEART DISEASE

DECEASED PERSON'S AGE:  
65

DECEASED PERSON'S GENDER:  
MALE

DECEASED PERSON'S RACE:  
WHITE

DECEASED PERSON'S HEIGHT:  
5'8"

DECEASED PERSON'S WEIGHT:  
180 lbs

DECEASED PERSON'S HAIR COLOR:  
GRAY

DECEASED PERSON'S EYE COLOR:  
BROWN

DECEASED PERSON'S BIRTH DATE:  
10/10/1892

DECEASED PERSON'S BIRTH PLACE:  
NEW YORK

DECEASED PERSON'S BIRTH PARENTS:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S MARRIAGE STATUS:  
MARRIED

DECEASED PERSON'S MARRIED PARENTS:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S CHILDREN:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S SIBLINGS:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S NEAREST RELATIVES:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S FRIENDS:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S EMPLOYERS:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S DOCTORS:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S NURSES:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S FUNERAL DIRECTOR:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S FUNERAL HOME:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S FUNERAL CHURCH:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S FUNERAL SERVICES:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S FUNERAL CEREMONY:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S FUNERAL BURIAL:  
JOHN D. DOWD, MARY JANE DOWD

DECEASED PERSON'S FUNERAL SERVICES:  
JOHN D. DOWD, MARY JANE DOWD

BUREAU V. 2

OCT 18 1957

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10457

51

10457

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Calvert</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b>		b. COUNTY <b>Calvert</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Prince Frederick</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Leonard</b> x2		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Calvert County Hospital</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Eleck</b>	Middle <b>H.</b>	Last <b>Parker</b>	4. DATE OF DEATH	Month <b>Oct. 21</b>	Day <b>1957</b>	Year
S. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH <b>Feb. 23, 1890</b>	9. AGE (In years lost birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months <b>0</b>	IF UNDER 24 HRS. Days <b>0</b>	Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired-Bus Driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Bus</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>John Parker</b>				14. MOTHER'S MAIDEN NAME <b>Edith Lloyd</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>128-01-6201</b>		17. INFORMANT <b>Mrs. Hazel Parker</b>		Address <b>St. Leonard, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Thrombosis</b> <span style="float: right;">INTERVAL BETWEEN ONSET AND DEATH</span>							
260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) <b>Diabetes Mellitus</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m.		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Oct 18</b> , 1957, to <b>Oct 21</b> , 1957, that I last saw the deceased alive on <b>Oct 24</b> , 1957, and that death occurred at <b>740</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Leonard, St. Leonard, Md.</b> DATE SIGNED <b>Oct 22</b>							
ACTUAL SIGNATURE <b>K. W. Ward</b>		M.D.					
PHYSICIAN'S NAME (Type) <b>R. E. V. Carrasco, St. Leonard, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL? (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 24, 1957</b>		22c. NAME OF CEMETERY OR CEMETARY <b>St. Paul's M.E. Cemetery</b>		22d. LOCATION (City, town, or county) <b>Bushy-Cabell Co.-Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>A. O. Harkness &amp; Son - Mutual, Inc.</b>		ADDRESS <b>101 W. Ward</b>		24a. REC'D BY REGISTRAR DATE <b>Oct 24, 1957</b>		24b. REGISTRAR'S SIGNATURE <b>K. W. Ward</b>	

## CERTIFICATE OF DEATH

DIA 101

MATERIALS

100-420-1

100-420-1

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RECEIVED  
OCT 25 1957

RECEIVED  
BUREAU V. S.

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician (and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial permit.

VS A15C 1-55 10/M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

10458

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

10458

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY CITY (If outside corporate limits, write RURAL OR TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS	Calvert Maryland Length of Stay (In this place)	STATE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN STREET ADDRESS	Maryland COUNTY Calvert (If rural give location)
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year) OF DEATH	
5. SEX M	6. COLOR OR RACE C	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH Aug. 16, 1957
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 64 yrs.
13. FATHER'S NAME David Smith		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	14. MOTHER'S MAIDEN NAME Mary Johnson
17. INFORMANT & ADDRESS Mrs. North Smith, Husby, Md		18. MEDICAL CERTIFICATION IMMEDIATE CAUSE (A) Hepatitis and C V R declared. ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) (C) Arteriosclerosis	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from 8/1/1957, to 10/22/1957, that I last saw the deceased alive on 10/11/1957, and that death occurred at 7:50 A.M., from the causes and on the date stated above. SIGNATURE H. W. Ward			
23. BURIAL/CREMATION, REMOVAL (SPECIFY)	DATE THEREOF 10-24-57	M.D. ADDRESS (Street, city, town, state) Hendleyton, Md DATE SIGNED 10/23/57	
24. REC'D BY REGISTRAR DATE 10-25-57	REGISTRAR'S SIGNATURE H. W. Ward	LOCATION (City, town, or county) Husby, Md	
25. FUNERAL DIRECTOR'S SIGNATURE F. E. Scull Prince Fred, Md		ADDRESS	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
 may be signed by the hospital or attending physician  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 2 and 2 should be filed with  
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
 Items 2 & 7, Film G222, 11/1/57 fcv  
 10459 **CERTIFICATE OF DEATH** 10459  
 Reg. Dist. No. **Baltimore**

1. PLACE OF DEATH a. COUNTY <b>Calvert</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>MARYLAND</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Huntingtown</b>		c. LENGTH OF STAY IN 1b <b>One.</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Private Home</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b> 28					
3. NAME OF DECEASED (Type or print) <b>Frances</b>		d. STREET ADDRESS <b>203 N. Beechwood Ave. Catonsville</b>					
4. SEX <b>F</b>	5. COLOR OR RACE <b>W</b>	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. DIVORCED <input type="checkbox"/>				
8. DATE OF BIRTH <b>Aug 3, 1872</b>	9. AGE (In years last birthday) <b>85 yrs.</b>	10. IF UNDER 1 YEAR <b>2 months</b>	11. IF UNDER 24 HRS. <b>22 days</b>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>					
11. BIRTHPLACE (State or foreign country) <b>Calvert Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>Joseph P. Gibson</b>		14. MOTHER'S MAIDEN NAME <b>Ginnie Mary Scheckler</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. - - -					
17. INFORMANT <b>D. Carroll Soper, Huntingtown, Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. <b>— Heart failure</b> (b) DUE TO <b>Coronary occlusion —</b> (c)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Huntingtown</b>	(County) <b>Baltimore</b> (State) <b>Md.</b>
21. I certify that I attended the deceased from <b>Oct 12</b> , 1957, to <b>Oct 25</b> , 1957, that I last saw the deceased alive on <b>Oct 12</b> , 1957, and that death occurred at <b>Huntingtown</b> , Md., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>St. Leonard St., Huntingtown, Md.</b>				DATE SIGNED <b>10/26</b>			
ACTUAL SIGNATURE <b>R. S. Soper</b>		PHYSICIAN'S NAME (Type) <b>R. D. Soper</b>		22a. PURATION, CREMATION, REMOVAL (Specify) <b>Burial Oct 28, 1957</b>			
22b. DATE THEREOF <b>Oct 28, 1957</b>		22c. NAME OF CEMETERY OR CREMATORIAL <b>Huntingtown Methodist</b>		22d. LOCATION (City, town, or county) <b>Huntingtown</b> (State) <b>Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>G. A. Harkness &amp; Son</b>		ADDRESS <b>Mt. Laurel, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>10-28-57</b>		24b. REGISTRAR'S SIGNATURE <b>H. W. Ward</b>	

CERTIFICATE OF DEATH

BUREAU X-5  
REGEVIEWED  
OCT 30 1957

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10460

## CERTIFICATE OF DEATH

Reg. Dist. No.

10460

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b <i>4 1/2 hrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>XO Bristol</i>		d. STREET ADDRESS <i></i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) FOR INSTITUTION <i>Calvert County Hospital</i>				d. STREET ADDRESS <i></i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <i>Mary</i>	Middle <i>Watkins</i>	Lost	4. DATE OF DEATH <i>10/2/57</i>	Month <i>10</i>	Day <i>2</i>	Year <i>1957</i>
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>5-1-01</i>	9. AGE (In years lost birthday) <i>56</i> yrs.	IF UNDER 1 YEAR Months <i></i>	IF UNDER 24 HRS. Days <i></i>	Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework</i>		10b. KIND OF BUSINESS OR INDUSTRY <i></i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Sherman Estep</i>		14. MOTHER'S MAIDEN NAME <i>Laura Estep</i>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Ethel Jones - Huntington, Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>443X</i>		DUE TO <i>Central Hemmangi</i>		INTERVAL BETWEEN ONSET AND DEATH			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. <i></i>		DUE TO <i>Hypertension C. S. d</i>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <i>Oct 2, 1957, to Oct 2, 1957</i>	(County)	(State)
21. I certify that I attended the deceased from <i>Oct 2, 1957</i> , and that death occurred at <i>Oct 2, 1957</i> , and that death occurred at <i>654A</i> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <i>81 Leonard</i>		DATE SIGNED <i>10/2/57</i>	
ACTUAL SIGNATURE <i>Edwlliams</i>	M.D.						
PHYSICIAN'S NAME (Type) <i>R. E. Williams</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-6-57</i>	22b. DATE THEREOF <i>10-6-57</i>	22c. NAME OF CEMETERY OR CREMATORIAL <i>Worley</i>	22d. LOCATION (City, town, or county) <i>A.A. Co. Md</i>				
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell. Prince Fred.</i>		ADDRESS	24a. REC'D BY REGISTRAR DATE <i>10/4/57</i>	24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours of death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10461 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10461  
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE <i>Md</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		c. LENGTH OF STAY IN 1b c. STREET ADDRESS <i>Indefinite</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>James</i>		First <i>James</i>	Middle <i>Walter</i>
4. DATE OF DEATH <i>10/24/57</i>		Month <i>10</i>	Day <i>1</i>
5. SEX <i>M</i>		6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH <i>6/24/45</i>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years from birthday) <i>12 yrs.</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <i>School</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>School</i>	
11. BIRTHPLACE (State or foreign country) <i>Gold</i>		12. CITIZEN OF WHAT COUNTRY? <i>Georgia Green</i>	
13. FATHER'S NAME <i>James Walter</i>		14. MOTHER'S MAIDEN NAME <i>Georgia Green</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>123-45-6789</i>	
17. INFORMANT <i>Hospital Records</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Angina pectoris and liver</i> DUE TO <i>900.0</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Fall on concrete steps while</i> DUE TO <i>playing with a soccer ball</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <i>Fell on steps playing soccer</i>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>9/27</i> 1957		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) <i>Calvert</i> (County) <i>Md</i> (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H.W. Ward</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>10/11/57</i>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-5-57</i>		22b. DATE THEREOF <i>10-5-57</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Carrolls</i>		22d. LOCATION (City, town, or county) <i>Barstow, Md</i> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>P. E. Sewell Prince Fred, Md</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>10-4-57</i>		24b. REGISTRAR'S SIGNATURE <i>H. W. Ward</i>	

BUREAU V. 2

OCT 7 1957

RECEIVED

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be retained within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

10462

10462

Reg. Dist. No. 51

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Calvert	MARYLAND	STATE
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)
TOWN	Adelina md	XO	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print)		4. DATE (Month) (Day) (Year)	
(First) Jane		(Middle) U. (Last) Willett	
5. SEX F	6. COLOR OR RACE C	7. SINGLE/MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH nov. 17, 58 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired), house work		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME John Henderson		14. MOTHER'S MAIDEN NAME Louise Egan	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS Roger Willett Adelina md	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 422.3 IMMEDIATE CAUSE (A) Chronic myocarditis.			
ANTECEDENT CAUSE(S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE DUE TO			
STATING UNDERLYING CAUSE LAST. DUE TO (C)			
INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While Not while M. at work <input type="checkbox"/> at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 10/10, 1956, to 10/23, 1957, that I last saw the deceased alive on 10/23, 1957, and that death occurred at 9 P.M., from the causes and on the date stated above.			
SIGNATURE		ADDRESS (Street, city, town, state)	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEROF 10-23-57 NAME OF CEMETERY OR CREMATORIAL Carrolls	
24. REC'D BY REGISTRAR DATE 10/28/57		REGISTRAR'S SIGNATURE H. W. Ward	
25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS P. E. Sewell, Jr. Funeral md.	

THE STATE DEPARTMENT OF HEALTH-ENVIRONMENT

CERTIFICATE OF DEATH

RECEIVED IN THE HOME DEPARTMENT

RECEIVED IN THE

ANNUAL

1957

1958

1958  
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1960

BUREAU V. 8

OCT 30 1957

RECEIVED